This form can be filled out while viewing in Adobe Acrobat Reader. Then print it and fax or mail to HID.



☐ Page 1 of 1 ☐ Page 1 of 2

# Alabama Medicaid Pharmacy
# Prior Authorization Request Form

**FAX: (800) 748-0116**
**Phone: (800) 748-0130**

**Fax or Mail to**
**Health Information Designs**

**P.O. Box 3210**
**Auburn, AL 36823-3210**

## PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____ Nursing home resident ☐ Yes

## PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

***I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.***

_____
**Prescribing Practitioner Signature** **Date**

## CLINICAL INFORMATION

Drug requested _____ Strength _____

J Code _____ Qty. _____ Days supply _____ PA Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Other _____
If applicable

Diagnosis or ICD-9 Code _____ Diagnosis or ICD-9 Code _____

☐ Initial Request ☐ Renewal ☐ Maintenance Therapy ☐ Acute Therapy

**Medical justification** _____

☐ **Additional medical justification attached.** **Medications received through coupons and samples are not acceptable as justification.**

## DRUG SPECIFIC INFORMATION

☐ ADD/ADHD Agents ☐ Alzheimer's Agent ☐ Antidepressants ☐ Antidiabetic Agent ☐ Antiemetic Agents
☐ Antihistamine ☐ Antihyperlipidemics ☐ Antihypertensives ☐ Antiinfective
☐ Anxiolytics, Sedatives and Hypnotics ☐ Cardiac Agents ☐ EENT-Antiallergics ☐ EENT-Vasoconstrictors
☐ Estrogens ☐ H2 Antagonist ☐ Intranasal Corticosteroids ☐ Narcotic Analgesics ☐ NSAID
☐ Platelet Aggregation Inhibitors ☐ PPI ☐ Respiratory Agents ☐ Skeletal Muscle Relaxants
☐ Skin & Mucous Membrane Agent ☐ Triptans ☐ Other

List previous drug usage and length of treatment as defined in instructions for drug class requested.

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

**If no previous drug usage, additional medical justification must be provided.**

## DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

**NOTE:** See Instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.alabama.gov

## ☐ Sustained Release Oral Opioid Agonist

Proposed duration of therapy _____ Is medicine for PRN use? ☐ Yes ☐ No
Type of pain ☐ Acute ☐ Chronic Severity of pain: ☐ Mild ☐ Moderate ☐ Severe
Is there a history of substance abuse or addiction? ☐ Yes ☐ No
If yes, is treatment plan attached? ☐ Yes ☐ No
Indicate prior and/or current analgesic therapy and alternative management choices
Drug/therapy _____ Reason for d/c _____
Drug/therapy _____ Reason for d/c _____

## ☐ Biological Injectables ☐ Remicade® ☐ Enbrel™ ☐ Kineret™ ☐ Humira™ ☐ Raptiva™ ☐ Amevive® ☐ Orencia®

Current weight _____ kg.

If rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis, is therapy approved by a board certified rheumatologist? ☐ Yes ☐ No
Prior and/or current DMARD therapy? ☐ Yes ☐ No If yes, attach documentation.
If Crohn's disease, is therapy approved by a board certified gastroenterologist? ☐ Yes ☐ No
If Remicade® is requested for rheumatoid arthritis, will patient be on Methotrexate? ☐ Yes ☐ No
If no, contraindication to use _____
If plaque psoriasis, is therapy approved by a board certified dermatologist? ☐ Yes ☐ No
If psoriatic arthritis, is therapy approved by a board certified dermatologist or rheumatologist? ☐ Yes ☐ No

**For Raptiva, Amevive or Enbrel**

Is the patient 18 years of age or older? ☐ Yes ☐ No
Is the patient with chronic moderate to severe plaque psoriasis a candidate for systemic therapy or phototherapy? ☐ Yes ☐ No
Has the patient failed 6 month treatment trials with topicals, generic OTC or brand, within the past year? ☐ Yes ☐ No

## ☐ Xenical®

☐ If initial request Weight _____ kg. Height _____ inches BMI _____ kg/m²
☐ If renewal request Previous weight _____ kg. Current weight _____ kg.
Documentation MD supervised exercise/diet regimen ≥ 6 mo.? ☐ Yes ☐ No Planned adjunctive therapy? ☐ Yes ☐ No

## ☐ Phosphodiesterase Inhibitors

Failure or inadequate response to the following alternate therapies:
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
Contraindication of alternate therapies: _____

☐ Documentation of vasoreactivity test attached ☐ Consultation with specialist attached

## ☐ Specialized Nutritionals

Height _____ inches Current weight _____ kg.
☐ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition
☐ If ≥ 21 years of age, record supports 100% of need is met by specialized nutrition
Method of administration _____ Duration _____ # of refills _____

## ☐ Xolair®

Current weight _____ kg.
Is treatment recommended by a board certified pulmonologist or allergist after their evaluation? ☐ Yes ☐ No
Is the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor **or** an inhaled corticosteroid and long acting beta agonist **or** has the patient required 3 or more bursts of oral steroids within the past 12 months? ☐ Yes ☐ No
Has the patient had a positive skin or blood test reaction to a perennial aeroallergen? ☐ Yes ☐ No
Is the patient 12 years of age or older? ☐ Yes ☐ No
Are the patient's baseline IgE levels between 30 IU/ml and 700 IU/ml? ☐ Yes ☐ No
Level: _____ Date: _____
Is the patient's weight between 30 and 150 kg? ☐ Yes ☐ No

**FOR HID USE ONLY**

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified
Comments _____

Reviewer's Signature

Response Date/Hour